GEORGIA DEPARTMENT OF HUMAN RESOURCES
Division of Mental Health, Developmental Disabilities and Addictive Diseases

APPLICATION TO BECOME A PROVIDER OF DEVELOPMENTAL DISABILITIES HOME AND COMMUNITY BASED WAIVER SERVICES

INDIVIDUAL APPLICATION

Please refer to the Application User's Guide for Instructions on completing this application.

SECTION I - APPLICATION TYPE

A. **New Developmental Disabilities (DD) Individual Provider** – Attendance at a Pre-Enrollment Training is a requirement prior to submission of application. Certificate of attendance must accompany application. If application is received without this documentation it will be returned to the applicant.

Individual applications are only to be completed by those persons with professional licenses to provide services under Adult Physical Therapy, Adult Occupational Therapy, Adult Speech Language Therapy, Behavioral Supports Consultation and Community Living Support (CLS) Nursing RN, LPN Services.

Individuals wishing to provide services to one individual with a developmental disability must be chosen by that individual with a developmental disability and work through the Self-Direction, or Co-Employer options.

Individuals wishing to provide other services to multiple individuals with developmental disabilities within the New Option Waiver (NOW) and Comprehensive Waiver (COMP) waiver must complete the Agency application and provide any Office of Regulatory Services (ORS) license relative to service.

Together with this application you MUST submit the Department of Community Health, Division of Medical Assistance Provider application (Medicaid application). This application may be accessed at: https://www.ghp.georgia.gov under Provider Information, or at the following link: Medicaid Provider Application.

Both applications MUST be submitted simultaneously to the Division of Mental Health Developmental Disabilities and Addictive Diseases (DMHDDAD)

B. Applicant Information

Name:			
Tax ID #:			
Street Address:			
City: County:	State:	Zip Code:	
Mailing Address (if different):			
City:	County:	State:	Zip Code:
Telephone:		Fax:	
Email Address:		Website:	
Type of Professional License (if applicable):			
License Number / Expiration Date:			
Category of Service: ❒ **680 New Option Waiver (NOW)** ❒ **681Comprehensive Supports Waiver (COMP)**			
Waiver Service:		HIPAA Code:	
Waiver Service:		HIPAA Code:	
Waiver Service:		HIPAA Code:	
Waiver Service:		HIPAA Code:	

Applicant's Name: _____

SECTION II - PROFESSIONAL AND GENERAL LIABILITY INFORMATION

In answering the questions listed below, if you answer YES, please provide documentation describing the circumstances surrounding the event, settlements, and or resolutions of the issues in the state of Georgia or in any other state.

A. Have you ever been named in any malpractice and/or other legal action within the last five (5) years? ☐ **Yes** ☐ **No**

B. Has your professional malpractice and / or liability insurance been canceled, non-renewed, restricted or special rated during the last five (5) years? ☐ **Yes** ☐ **No**

C. Has any government agency in the state of Georgia or any other state investigated, suspended, revoked or taken any other action against you within the last five (5) years? ☐ **Yes** ☐ **No**

D. At any time has any license, specialty board certification or eligibility been revoked, reduced, denied, or suspended by the issuing entity or voluntarily given up by you within the last five (5) years? ☐ **Yes** ☐ **No**

E. Have you had any legal actions brought against you within the last five (5) years or are there any legal actions currently pending against you? ☐ **Yes** ☐ **No**

F. Have you received any sanction letters or related documents from any licensing, certifying or credentialing entity within the last five (5) years? ☐ **Yes** ☐ **No**

G. If you answered "Yes" to any of the questions in paragraphs C, D, E or F above, did it result in termination or suspension of your contract or agreement with any government agency in the state of Georgia or in any other state within the last five (5) years? ☐ **Yes** ☐ **No**

H. Have you been debarred or suspended from receiving payment under the Medicare and/or Medicaid Program within the last five (5) years? ☐ **Yes** ☐ **No**

Authorized Agent

Under applicable state and federal laws, I do hereby attest that the information contained in this application is complete, true, and correct.

_____ _____

Name of Organization (please print) Name of CEO/Director/Owner (please print)

_____ _____

Signature of CEO/Director/Owner Date

SECTION III-PREVIOUS PROVIDER EXPERIENCE

1. List any and all Georgia Medicaid Provider Number(s) issued to you with corresponding service and the region in which services are/were provided.

Medicaid Number	Service Provided	Region	Is Number Active or Terminated?

2. Please list any previous Contracts, Letters of Agreement (LOA) or Provider Agreements (PA) issued to you by the Department of Human Resources (DHR) within the last five years.

Name used on Contract, Letters of Agreement or Provider Agreements	DHR Division Issuing	Brief Description of the Scope of Work

3. Please list any services you delivered to citizens with developmental disabilities within the past five years.

Name of Service	Location of Service

SECTION IV - QUALIFICATIONS AND REQUIRED INFORMATION

The following documents MUST be submitted with this application:

1. **Current Resume**

2. **Georgia professional license, if applicable**

3. **Copy of degree or diploma as required for the service(s) for which you are applying. (See Department of Community Health and Division of Mental Health, Developmental Disabilities and Provider Manual for requirements)**

4. **Copy of a national criminal records check (NCIC), or a Georgia Crime Information Center (CGIC), or a local law enforcement agency (police department), which includes no criminal record for any of the covered crime outlines in O.C.G.A Section 49-2-14-1 et. Seq. (*See 2008 Provider Manual; Section IV: "Criminal Records Checks and Investigations").* The satisfactory criminal background check must have been completed during the last twelve (12) months and be completed before working with participants.**

5. **Copy of Commercial General Liability Insurance listing the State of Georgia as Certificate Holder:**

   State of Georgia
   Department of Human Resources
   Division of MHDDAD
   # 2 Peachtree Street, 23rd Floor
   Atlanta, GA 30303

   The insurance requirements can be found in the Division's Provider Manual – Financial Policies and Reporting Requirements (http://www.mhddad.dhr.georgia.gov)

6. **Department of Community Health (DCH) Medicaid Provider Enrollment Application.**

7. **Policies and Procedures:**

   a. **Description of Service(s) to be provided**
   b. **Medication Management**
   c. **Incident / Accident and Death Reporting and Investigation**
   d. **Behavior Management (Positive behavior support plan, safety plan, inform consent)**

ATTESTATIONS

Developmental Disabilities Services

The Georgia Department of Human Resources requires that services be provided according to the service guidelines and that the agency will operate in accordance with applicable standards, rules and regulations and policies.

A. I do hereby certify that I have received, read and agree to comply with the terms and conditions set forth in the following:

Division of MHDDAD current Provider Manual found at the following link:

Division of Mental Health, Developmental Disabilities and Addictive Diseases (MHDDAD) - Provider Manual

Department of Community Health (DCH) Policies and Procedures Manuals, found at the following links:

- Part I Policies and Procedures / Billing Manual
- Part II– Policies and Procedures for NEW OPTIONS WAIVER PROGRAM (NOW) formerly Mental Retardation Waiver Program Services General Manual
- Part III– Policies and Procedures for NEW OPTIONS WAIVER PROGRAM (NOW) formerly Mental Retardation Waiver Program Services
- Part II– Policies and Procedures for COMPREHENSIVE SUPPORTS WAIVER PROGRAM (COMP) formerly Community Habitation Support Services General Manual
- Part III– Policies and Procedures for COMPREHENSIVE SUPPORTS WAIVER PROGRAM (COMP) formerly Community Habitation Support Services
- Rules and Regulations of Department of Human Resources Division of MHDDAD - Client's Rights (Chapter 290-4-9).

B. I hereby certify that I:

- **Am at least 18 years of age**
- **Have current CPR certification**
- **Have a current First Aid certification**

C. Under applicable state and federal laws, I do hereby attest that the information contained in this application is complete, true, and correct.

_____
Name (please print)

_____
Signature

_____
Date